Agency Code	Subagency Code

Public Employees Benefits Board

Long Term Disability (LTD) Enrollment/Change Form

- Type or print clearly in ink.
- Shaded areas are for agency use only.
- Return this form to your payroll or insurance office.

NOTE: Inaccurate, incomplete, or illegible information may delay your coverage.

Note to Agencies: Review for completeness and accuracy, and key guaranteed issues before submitting to Standard Insurance Company.

Social Security Number	Date of Birth (MO/DAY/YR)	☐ Male ☐ Female	Phone: Work ( ) Home ( )

Agency Name and Division

First Name	Middle Initial	Last Name

House Number	Street Address	Apt./Unit Number

City	State	ZIP Code + 4

Current Agency Hire Date (MO/DAY/YR)

☐ **NEW ENROLLMENT**
Evidence of insurability required if beyond first 31 days of eligibility

☐ **DECREASE IN WAITING PERIOD**
Evidence of insurability required

☐ **NOT ELIGIBLE FOR OPTIONAL COVERAGE**

☐ **INCREASE IN WAITING PERIOD**

☐ **CANCEL OPTIONAL COVERAGE**

Original Insurance Eligibility Date (MO/DAY/YR)

Effective Date if **No** Approval Required (MO/DAY/YR)

Monthly Earnings
$

Effective Date After Approval **(For Agency Use)**

I wish to enroll in the optional LTD Plan.
☐ Yes ☐ No

If yes, choose a waiting period.

☐ 30 Days	☐ 180 Days
☐ 60 Days	☐ 240 Days
☐ 90 Days	☐ 300 Days
☐ 120 Days	☐ 360 Days

Note: Refer to your booklet certificate for premium amounts and other plan details.

For Agency Use Comments

Current coverage:

Basic only ☐ Optional _____

I hereby declare that to the best of my knowledge I am eligible for the coverage requested. I authorize my employer to deduct from my earnings any premium I am required to pay for the coverage I have selected. By signing this form, I attest to the fact that I have read the notice on the back of this form pertaining to application for Long Term Disability coverage. This form supersedes all previous forms I have submitted for Public Employees Benefits Board Long Term Disability coverage. A deposit of premium payment does not guarantee coverage and will be refunded if I am determined to be ineligible for coverage.

Signed: Date:

I hereby **reject** my opportunity to enroll in optional Long Term Disability coverage. I have checked "No" under "I wish to enroll in the optional LTD Plan" or left the check box blank.

Washington State law may require disclosure of any information you submit as a public record. The HCA's Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.

Signed: Date:

Comments	For Agency Use	Standard Insurance Co.
	Date sent to carrier _____ Date / Initials	Approved ☐ Declined ☐ Incomplete ☐ _____ Date / Initials

Information Practices Notice

To help us determine your eligibility for group insurance, we may request information about you from other persons and organizations. For example, we may request information from your doctor or hospital, other insurance companies, or Medical Information Bureau, Inc. (MIB). We will use the authorization you signed on the front side of this form when we seek this information.

MIB information that we collect about you is confidential. However, Standard Insurance Company may make a brief report to the MIB. MIB is a nonprofit corporation. It exchanges information among its member life insurance companies. If you later apply to another MIB member company for life or health insurance coverage, or if you submit a claim for benefits to such a member company, MIB will supply the member company with any information it has about you in its files. This will be done only upon the member company's request. Standard may also release information about you to other insurance companies to whom you have applied for life or health insurance or made a claim for benefits.

MIB will disclose any information it has about you at your request. However, medical information will be released only to your attending physician. If you believe that the information MIB has about you is incorrect, you may contact MIB and request a correction. Your request for correction will be handled by MIB in accordance with the procedures outlined in the federal Fair Credit Reporting Act. The address of the MIB information office is: 160 University Avenue, Westwood, Massachusetts 02091. MIB's telephone number is 781-329-4500.

DISCLOSURE TO OTHERS—The information collected about you is confidential. We will not release any information about you without your authorization, except to the extent necessary to conduct our business or as required or permitted by law.

DISCLOSURE TO OTHERS—You have a right to know what we have about you in our underwriting file. You also have a right to ask us to correct any information you think is incorrect. We will carefully review your request and make changes when justified. If you would like more information about this right or our information practices, please write to us.

Group Medical Underwriting Department, G-18
Standard Insurance Company
P.O. Box 711
Portland, OR 97207

PLEASE RETAIN A COPY OF THIS NOTICE FOR YOUR RECORDS.